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ORIGINAL ARTICLES.

SHORTENING, BY OPERATION, THE BONES OF THE LIMBS IN THE TREATMENT OF INJURIES COMPLICATED WITH EXTENSIVE DESTRUCTION OF THE SOFT PARTS.

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In two numbers of the *Journal of the American Medical Association*, viz : Aug. 14, 1886, and Jan. 22, 1887, reference is made to cases coming under the above heading. The earlier number contains an abstract from the *Gazette Medicale de Paris* (Feb. 27th, March 13th and 20th, 1886), of a report by Dr. Martel, of St. Malo. Dr. M's case was a compound fracture of the tibia and fibula, in which 75 millimetres of both bones were resected. The result was highly satisfactory, with seven to eight centimetres shortening. Dr. Martel mentions as the only other case analogous to his own, one reported in the *Centralblatt f. Chirurgie*, No. 50, 1884, by Karl Loebker, who resected both bones of the forearm, in order to facilitate suture of divided nerves and tendons.

In the January number of the *Association Journal* reference is made to both the foregoing cases by Dr. W. D. Hamilton, of Columbus, Ohio, who adds a third to the list, wherein he resected two inches of the tibia and fibula, on account of a compound fracture. The result was excellent, with about two inches shortening.

For the benefit of those interested in this most important branch of surgery, I will report in full a case treated at the Southern Pacific Company's Hospital, Sacramento, during the months of May *et seq.* 1884. Brief mention of it was made in a paper entitled "Notes on Antiseptic Surgery," (*Pacific Medical and Surgical Journal*, April, 1885), ten months prior to Dr. Martel's publication, and twenty-one months prior to that of Dr. Hamilton. At time of operation I regarded my case as unique. The following is an abstract from the Hospital record :

On May 1st, 1884, R—— F——, aged thirteen years, an apprentice in railroad boiler shop, was brought to Hospital, having sustained an injury to right forearm and wrist by being impaled upon a rapidly revolving drill. The external wound was as follows : from a point over dorsum of radius, $1\frac{1}{2}$ inches above wrist joint, the integument was torn quite smoothly in a spiral direction to a point over palmar surface of radius, about $2\frac{1}{2}$ inches above wrist articulation. The underlying soft parts were greatly lacerated ; no active hæmorrhage. The radius was fractured irregularly $1\frac{1}{2}$ inches from wrist articulation, and the ulna was separated at its epiphysis. The radius was also fractured longitudinally for nearly two inches, and the upper extremities of both bones were denuded of periosteum for about two inches.

Assisted by Dr. H. W. Nelson, of this city, I performed a non-symmetrical resection of both bones, as follows : $2\frac{3}{8}$ inches of radius from point of fracture toward middle, and the same length from the distal end of ulna, including the epiphysis. The divided ends of radius were approximated, but not wired, the end of ulna now occupying the place vacated by the resected portion of ulna. A careful antiseptic dressing was applied and the forearm and hand were laid on a posterior splint. The external wound healed perfectly in five days. The radial fragments were united firmly by August 2d. Owing to early separation of these fragments and subsequent filling up of the intervening space, but $1\frac{1}{4}$ inch

shortening was noted at this time. On September 29th he fell, striking affected forearm violently across the edge of a box, refracturing radius at point of resection. On the 11th of November, 1884, union was perfect. The radius was again refractured December 3d, 1884, which reunited in a short time. The last note made by me was as follows: "Dec. 27, '84. Fracture united. Parts in good line. Discharged."

The following observations, recorded by Dr. J. H. Parkinson, of Sacramento, eleven months after the original injury, are of interest as bearing upon the results attainable in such cases.

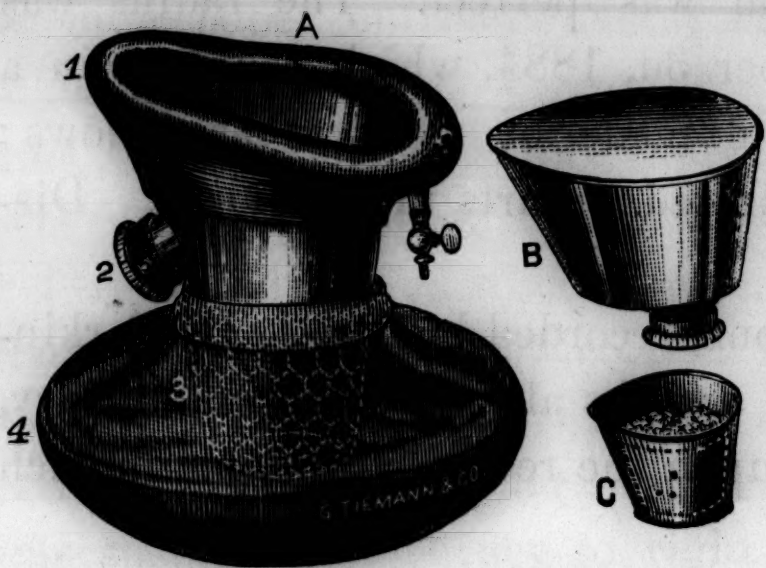
	AFFECTED SIDE.	SOUND SIDE.
Circumference at wrist.....	5 $\frac{3}{8}$ in.	6 $\frac{1}{2}$ in.
At insertion pronator radii teres.....	7 $\frac{3}{8}$ in.	9 $\frac{1}{4}$ in.
Length from internal condyle to head of ulna..	8 $\frac{1}{2}$ in.	10 in.
Length from internal condyle to head of radius,	8 $\frac{1}{2}$ in.	10 in.

"Flexion = half normal. Extension : cannot raise hand. Pronation = half normal. Supination, half normal. Can grasp three fingers with faint force. Approximating power of thumb, very deficient. The hand is adducted, the distal portion of radius being at a slight angle as regards the proximal portion. Sensation of skin supplied by ulnar nerve seems deficient; median, impaired; radial, uninjured; radial artery, intact; ulnar artery, imperceptible."

In July, 1886, unfortunately, the radius was refractured a third time (not including the original injury). It was carefully treated as before, but for some unexplained cause failed to reunite. At present there is noted firm fibrous union, with marked increase of pre-existing angularity. The usefulness of the hand has continued to increase. At date the grasping power is excellent. The thumb can be readily approximated to each of the fingers. He is able to do the ordinary work of a mechanic—the parts being supported by a leather wristlet. Strange as it may seem, this improvement has not been interrupted by the last injury.

AN IMPROVED ETHER INHALER.

By JAMES H. PARKINSON, L. R. C. S. I.



A. Inhaler ready for use. B. Ether reservoir.
C. Ether measure, showing sponge inside.
1. Air cushion inflated. 2. Air cap. 3. Wire
net basket to contain sponge. 4. Rubber
bag collapsed.

In presenting this apparatus to the notice of the profession, I wish at the outset to disclaim any idea of misappropriation. The instrument is in principle identical with Ormsby's inhaler, the best points of which have been utilized. A practical experience of some nine

years with the original apparatus, has induced me to modify it, so that a compact, efficient, and inexpensive inhaler could be obtained by any practitioner. The improvements are the substitution of rigid, instead of flexible metal in the face piece; the omission of the ether supply tubes, and the modification of minor details throughout.

The apparatus consists of a metallic face piece, the base of which corresponds to the usual facial lines. To the upper part of this is fastened a wire net basket, around the mouth of which, and projecting into the face piece is a small gutter, which prevents ether or moisture from dropping on the patient. On one side of the face piece is an air cap, which exposes or covers a slot on rotation. A collapsible rubber bag, shaped somewhat like a cranial ice cap, is attached to the face piece, its elastic neck grasping the apex of the latter, where a groove has been made for its reception. A rubber air cushion fits over the base of the face piece, maintaining its position by a lip which forms part of the cushion.

To prepare the inhaler for use, when the temperature of the room is below 65°, place a small napkin or towel, wrung out of very hot water, in the face piece for a few minutes.

The sponge, which should have an absorption capacity of two ounces, is soaked, squeezed dry, and placed in the wire net cone, so that every part is above the gutter. The air cushion is then fitted and *partially* inflated. Pour one ounce, by measure, of Squibbs' ether on the sponge and place the inhaler on the face, with the air slot wide open. This should be closed after three or four inspirations. During the progress of an operation, fresh ether is added, as required, in quantities of four drachms. If used for half an hour it is advisable to remove the sponge and squeeze out the moisture which has formed by condensation.

The points of superiority claimed for this inhaler are, that it is compact, portable and inexpensive. It is simple in construction, and the rubber portions when worn out are easily duplicated. It is most economical in the use of ether, and the unpleasant odor of the drug by diffusion is absent. With it the production of anesthesia is a certainty. The rapidity of its action will equal any apparatus, and there is no method of ether administration which surpasses it in safety.

Amongst the objections raised are those common to all permanent apparati: that it is dirty, and that infective matter will adhere to it, or may lodge in the sponge. The simplicity of its construction admits of a ready and perfect cleansing; and no part will be injured by hot water, or antiseptic solutions which are familiar to most practitioners. Against the inhaler *per se* it is urged that the anesthesia partakes largely of carbonic di-oxide poisoning—that this is a source of danger, and an inseparable defect.

The re-breathing of the ether charged air with a small atmospheric mixture, is the main point on which the superiority of the inhaler rests. That it is not in any sense a defect or danger, practical experience of several years has proved; and in support of the position, I will quote three opinions.

Prigden Teale, writing in the *British Medical Journal*, says: "The patient breathes the same air over and over again, * * thereby economizing the heat of the air passages,

economizing ether, and enhancing the effect of the ether by partial asphyxia."

Mr. Woodhouse Braine, Lecturer on Anesthetics at Charging Cross Hospital, states that in using the inhaler he frequently removes the sponge, and maintains anesthesia by allowing the patient to breathe into and from the rubber bag. He says: "It may be urged against this method that the patient re-breathes the carbonic acid of his own expired air, and this is true: but from the length of time I have employed this plan, and from never having seen any deleterious results from it, I do not attach any importance to the objection."

Mr. Ormsby, in reply to an inquiry, has kindly written: "I believe that carbonic di-oxide in a diluted form assists the ether as an anesthetic, while the re-breathing of the vapor warms it, so that it is more readily tolerated by the patient."

In my own experience, which has been extended and considerable, I have found no disadvantage arising from the alleged asphyxiation. I would add a few hints as to the method of administration, omitting the usual preliminaries and precautions which should be observed during the progress of anesthesia. Always measure the ether used, for economy and in order to *know* how much is being consumed. A given quantity will yield a certain result. This precision which obtains in the majority of cases contributes largely to the saving in the drug. Having poured the ether on the sponge, invert the inhaler before placing it on the patient's face, to be certain that no fluid will escape and startle him.

As a preliminary I usually apply the inhaler with the air slot open, and direct the patient to keep the mouth closed and breathe slowly and quietly. This may seem a triviality, but I am satisfied from personal experiment and frequent experience, that when closely followed it completely abolishes the troublesome cough which usually accompanies the first inspirations. In slowly passing through the nasal cavities, the vapor is warmed, and fails to irritate the laryngeal mucous membrane. In the lungs the presence of the

reserve air at first assists to dilute the vapor, and as insensibility sets in the the respiration deepens. The inhaler should be pressed firmly in the face to diminish leakage. When anesthesia is complete the instrument should be removed and re-applied as occasion demands.

In consequence of a letter which appeared in the *Journal of the American Medical Association*, for October 16th, 1886, I have received many inquiries as to an inhaler which would give the results there stated. Ormsby's figures for the old apparatus were :

Average time required to produce insensibility, 2 minutes.

Average quantity of ether employed, 1 oz.

This is a fair statement when calculated from a large number of cases, and the improved inhaler will give as good results. With a view to making the apparatus complete, I have had a leather case constructed, which will contain the inhaler, with the air cushion and a tongue forceps. The interior of the basket is occupied by the cup measure, into which the sponge is pressed, while in the face piece and accurately fitting it is an ether reservoir, having a capacity of 10 oz. The merit of this combination is that the smallest case which will contain the inhaler *alone*, will also hold all the rest.

Mr. Richard Barwell, in a paper read before "The Royal Medical and Chirurgical Society," advocates a safe method of treating hydatids of the liver, where evacuation with a trocar had failed to cure. He advises that the cyst be widely incised and the opening kept patent for some time. He first incises the abdominal parietes, stitching them to the cyst or its surroundings, and then, after a few days, cuts into the tumor.—(*British Medical Journal* January 28th, 1887.)

OBSTETRICS, DISEASES OF WOMEN AND OF CHILDREN.

By WALLACE A. BRIGGS, M. D.

A NEW THEORY OF MENSTRUATION.—In the *Arch. f. Gynækol.* (1884) Dr. Loewenthal announces a new interpretation of the phenomena of menstruation, of which the following is a summary, as presented in *Schmidt's Jahrbuecher*, No. 9, 1885:

1. On rupture of a follicle the mature ovum escapes and passes on to the uterus.

2. The ovum imbeds itself, ordinarily, in a fold of the uterine mucosa, in the neighborhood of the uterine orifice of the Fallopian tube, and, as a direct consequence of its presence, excites a hyperplasia of the uterine mucous membrane.

3. If the ovum is now fecundated, the decidua of menstruation develops into that of pregnancy.

4. If not fecundated within a certain time it dies, and thus causes active congestion as well as the breaking-down of the menstrual decidua, followed by the menstrual flow.

5. The congestion thus developed reacts on its mediate cause, the ovary, and promotes the rupture of another follicle and the escape of its mature ovum.

The cycle is thus complete, and repeats itself more or less regularly from puberty to the climacteric.

The clinical applications of this theory are very important. Loewenthal says: According to my conception of the nexus of menstrual phenomena it is clear that the menstrual flow must be regarded with entirely different eyes than heretofore. For me it can be nothing else than an altogether unnecessary and, at times, pathological consequence of a process which of itself is no longer quite physiological—the death of an ovum unfructified in spite of its normal embedment.

The flow has all of the qualities and effects of other pathological hæmorrhages. The indication is, therefore, to limit the menstrual loss as much as possible. For this purpose rest in bed and vaginal irrigation with hot water (50° C.—

122° F.) are to be recommended. Loewenthal relates several cases in which this treatment was pursued with the most gratifying improvement in the general health. This treatment, however, he would apply only to those cases in which the health is impaired by the menstrual loss. The normal woman is not well because she menstruates, but notwithstanding she menstruates.

Other applications will occur to the thoughtful physician, as in incipient phthisis, in chlorosis and in debility from whatever cause.

ERYSIPELAS AND PUERPERAL FEVER.—That a certain mutual causal relation exists between erysipelas and puerperal fever is the opinion of English physicians. Virchow also has maintained their identity.

By a series of observations, Gusserow has reached the conclusion that no connection exists between puerperal sepsis and erysipelas. These observations were made in 1879, and, in the meantime, the discovery of the cocci of erysipelas has firmly established the specific nature of this disease. The cases were, in brief, as follows:

1. A woman nearing the close of pregnancy fell sick with a mild erysipelas, beginning in the right cheek. On the fifth day of the disease a mature child was born; in four days the temperature was normal. The disease was purely accidental and without influence on either labor or lying-in.

2. In the eighth month of pregnancy a severe erysipelas began in the left thigh and extended over the entire body. On the sixteenth day it led to labor, delivery, and, a few minutes later, to death. The autopsy revealed the following interesting points: the uterus lay high above the pelvis; the peritoneal cavity, as well as Douglas' cul de sac, the uterus and its annexes were perfectly normal.

3. On the fourth day of lying-in, erysipelas appeared in the face and ran its course without affecting the child-bed in any way.

4. On the eighth day of a previously normal lying-in, erysipelas of the right mamma developed from a fissure and terminated in death on the seventh day. The child took sick with facial erysipelas two days before the death of the mother and died on the third day of the disease. On post mortem the uterus was found undergoing normal involution; the ovaries, the ligamenta lata, and all the surroundings of the uterus and of the vagina were found healthy.

Erysipelas in the foregoing cases was undoubtedly a mere accident of pregnancy and child-bed. More doubtful, however, in Gusserow's opinion, was the fifth case, in which, on the tenth day, peri and parametritis developed with high fever. On the sixth day of the disease erysipelas made its appearance in a leech-bite, spread over the abdominal walls, and lasted ten days. The parametritis ended in abscess, which broke spontaneously into the rectum.

The next nine cases occurred during a considerable epidemic of so-called puerperal fever. The ratio of these cases to those of puerperal sepsis was very small, and on this ground the author regards as quite unwarranted the assumption that erysipelas gives rise to the puerperal infection. The author, therefore, asserts, with Fehleisen, that erysipelas does not give rise to puerperal fever. The proof of this opinion is furnished by the discovery of the peculiar micrococcus of erysipelas.—(*Arch. f. Gynækol.*—*Schmidt's Jahrbuecher*, No. I B. 209.)

WHEN SHOULD THE CORD BE TIED.—Recent investigations have established the fact that the placental circulation does not cease immediately after the birth of the child. On the contrary, it continues a while, and thus forms a transition period between the intra uterine and the extra-uterine life of the infant. At the beginning of this period Budin estimates that, on the average, 92 grams (about 3 ozs.) of blood still remain in the placental circulation, and this is wholly lost to the infant if the cord be tied at this time. A number of

other authors have tried to determine the quantity of blood lost under these circumstances.

But since these observations determine merely the quantity of blood circulating in the placenta, and not the quantity that really reaches the child in consequence of a later division of the cord, they are all in this respect defective. For, during this transition period, the blood is conveyed not only by the arteries to the placenta, but also by the veins to the child; the preponderance of the latter over the former is the net gain. This preponderance can be determined only by the difference between the weight of the child immediately after birth and its weight after the placental circulation has ceased. With every precaution, Dr. Engel has taken these weights in 60 cases, of which 24 were premature labors. With full-term children, the greatest increase in weight was 70 grams (about $2\frac{1}{5}$ ozs.): with premature children, 90 grams (about $2\frac{4}{5}$ ozs.). With the latter the pulsation of the cord ordinarily lasted longer than with the former.

That the child profits by late division of the cord, it is now positively determined. But what is the cause of this physiological transfusion, and of what import is it to the child?

According to some, the moving force of this transfusion is aspiration; according to others, it is the powerful contractions of the uterus in the third stage of labor. Neither of these factors, according to the author's searching investigations, is to be considered the cause of the transfer of blood, whose possibility and extent are rather dependent on the inverse ratio of two opposing forces—the activity of the heart, and the contractility of the vessels. The heart contractions force the blood through the arteries to the placenta, but still permit its return by the veins, and thus promote for a time the circulation through the cord. On the other hand, by the external cold the vessels of the cord and of the placenta (?) are excited to a contraction that hinders and finally cuts off this circulation. Since their walls are less contractile the

veins remain pervious longer than do the arteries, and thus permit the return of the placental blood to the child.

By late tying of the cord the child profits to the extent of a third or a fourth of its entire blood supply, and manifests the physiological significance of this gain in vital fluid by its ruddier appearance, by its quieter behavior, by its later nursing, by its slighter somnolence, by its markedly diminished tendency to icterus, by its seemingly slighter loss of weight during the first few days of independent existence, and, lastly, by its greater viability.

The author, however, cannot concede to this blood-gain the great influence attributed to it by Budin in the resuscitation of the new-born.—(*Centr.-Bl. f. Gynækol.—Schmidt's Jahrbuecher, B. 209, No. 2.*)

THE DEPENDENCE OF GASTRIC NEUROSES ON UTERINE DISEASE.—The first case is that of a strong woman of 25 years, the mother of one child. She fell sick with great emotional disturbance, accompanied by gastric irritation, which soon increased to such a degree that all foods were rejected. Finding no disease of the stomach, after repeated examinations, the author assumed the existence of a neurosis of this organ. The patient emaciated greatly, even while undergoing a "cure" at Carlsbad, when food was retained for a considerable period. Soon after this cure, however, the old troubles returned, and their dependence on disease of the generative organs was suspected. On careful examination the only morbid condition discovered was extreme mobility of the uterus. Immediately after the introduction of a Hodge-Braun pessary improvement set in, the vomiting ceased, and within four months the greatly enfeebled patient was restored to her usual health.

The second case is that of a woman of 30 years, who, soon after getting up from a normal labor, began to experience unpleasant sensations in the region of the stomach. On being about for some time vomiting set in, and gradually in-

creased in frequency. At first, the vomiting ceased when the patient lay quietly on her back, but later this was without effect. When the patient had become extremely thin, Dr. Braun discovered an ectropion of the cervix uteri. Touching of the everted mucous membrane excited efforts at vomiting. The vomiting ceased after the performance of hysterotrachelorrhaphy, and in a few months the patient recovered her former blooming health. In Dr. Braun's opinion the vomiting was caused by friction and traction of the ectropic surface, produced by walking and sitting. When a normal portio-vaginalis was restored by operation, the uterus was no longer a source of reflex irritation.

The third case is that of a woman of 28 years, who suffered fearful gastric pain, and finally vomiting, which were relieved only by rest in bed. On account of descensus uteri several pessaries had already been introduced, but either they had been ineffectual or they had not been tolerated. The author then discovered that the right kidney was remarkably movable, and that the low-lying uterus was abnormally large—5.6 inches in depth. After several weeks of quiet recumbence the uterus had diminished two-fifths of an inch in depth, but still, even after the application of a bandage to restrain the movements of the kidney, on getting up the former troubles returned. Amputation of the portio-vaginalis was now done. The operation passed off smoothly, and, during the after-treatment, vomiting did not occur. The depth of the uterus was reduced to 3.2 inches, and both the bearing-down and the vomiting were permanently relieved.—(*Wien. Med. Wchnsch.—Schmidt's Jahrbuecher, B. 212, No. 12.*)

The *Medical Record* (January 1, 1887), states that three cases of beri-beri were admitted to Bellevue Hospital from a ship clearing from San Francisco. Two of these proved fatal. Nearly all of the crew had been attacked on the voyage, and several died.

SURGERY AND PATHOLOGY.

By THOS. W. HUNTINGTON, B. A., M. D., Surgeon S. P. Co.'s Hospital,
Sacramento, Cal.

Provided the treatment of aneurism of the abdominal aorta by depositing within the sac a coil of wire is an assured success, the field of abdominal surgery will be greatly enlarged, and the very considerable number of sufferers from this cause will hail the announcement with delight.

The case reported by Dr. Morse, of San Francisco, in the February number of the *Pacific Medical and Surgical Journal*, is an achievement worthy of more than passing notice. The future of the case in point will be watched by the profession with marked interest, and if it be not attended by a relapse, the time is not far distant when the first successful case treated by Loreta's method will be recruited by many of its kind.

In the "Proceedings of the Leeds and West Riding Medico-Chirurgical Society," as reported in the *British Medical Journal* of Jan. 1, 1887, reference is made to three successful suprapubic lithotomies by Mr. McGill.

This plan of removing vesical calculus is justly attracting very considerable and favorable comment. The elevation of the fundus of the distended bladder through the agency of a water-bag in the rectum, simplifies the operation in two ways:

First.—The bladder being forced against the anterior abdominal wall, and there supported until the margins of the incisions can be grasped and securely held by assistants, the escape of urine into the abdominal cavity is practically obviated.

Second.—Pressure from below increasing the triangular suprapubic space, the danger of wounding the peritoneum is thereby measurably lessened.

The main points of superiority of this operation over the lateral, as maintained by Sir Henry Thompson (*British Medical Journal*, Oct. 2, 1886), are as follows:

"1. Because in the suprapubic operation there are no important structures lying in the line of the incision, or sufficiently near to be rendered liable to injury by the knife or forceps.

"2. Because the space for removing a large stone above the pubis is practically unlimited.

"3. Because there is little or no danger to be apprehended from hæmorrhage, and if it does occur, it may be readily dealt with.

"4. Because the incisions are certainly more easy to perform than those of lateral lithotomy, while the removal of a large stone is safely and easily effected.

"5. Because during the after-treatment the urine leaves the suprapubic wound more directly and more safely than it does by the long and lacerated opening from the bladder to the perineal surface after the lateral operation.

"6. Because antiseptic dressings can be employed in the former operation, and cannot be made available in the latter."

Mr. Skene Keith, at a meeting of "The Medico-Chirurgical Society of Edinburgh," described twenty-four successful operations for removal of the appendages. In the majority of these, the ultimate result had been good. The number of cases suitable for operation had decreased; at least he and his father, Dr. Thomas Keith, had met with fewer cases. He believed that the main factors, in inducing a diseased state, were laceration of the cervix and certain methods of treatment which were much in vogue in some quarters. He thought that the routine passage of the sound was an important causal element, and he deprecated certain forms of intra-uterine medication. The connection of syphilis and gonorrhœa with the morbid state of the appendages seemed more doubtful. In only one of the cases which he or his father had seen was there any suspicion of gonorrhœa.—(*British Medical Journal*, January 29th, 1887.)

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

By WM. ELLERY. BRIGGS, M. D.

Dr. C. Higgins makes the following remarks "On the Relation of Headache to the Condition of the Eyes," in the *British Medical Journal* of January 15th:

Headache, arising from ocular causes, is very frequently met with. Ophthalmic surgeons have again and again called attention to the subject; but as yet the bulk of the profession do not appear to recognize the necessity for a thorough examination of the eyes in all cases of obstinate head-pain.

As a rule, when a case of ocular headache comes before the ophthalmic surgeon, the patient has undergone a protracted course of medical treatment, having been looked upon as nervous, plethoric, bilious, or anæmic. Indeed, in some cases, after having "suffered many things of my physician," a patient has been pronounced the subject of incurable brain-disease, when all that was necessary to effect a cure was a properly selected pair of spectacles.

The symptoms of ocular headache are fairly well marked; they nearly always begin in early life, though a reference to any ophthalmic surgeon's case-book will show that, in many instances, the cause has never been discovered till late in life. "I have had headache as long as I can remember," or "I have had headache off and on ever since I first went to school," is what we are frequently told. The most marked symptom is, that the headache is either brought on, or made worse, by reading or working. The ocular conditions causing headache are anomalies of refraction (hypermetropia and myopia), astigmatism, and insufficiency of the internal recti muscles. All these conditions are easily remedied by optical means, but are quite beyond the reach of medical treatment. I have looked over two of my case-books, containing rough notes of 1072 cases, and find that thirty-one, or nearly three per cent., suffered from obstinate headache, which appeared to be due to the condition of the eyes.

I have said that treatment by optical means is all that is necessary in these cases. This is not quite all, however. In the cases of children and young adults, more especially young ladies, we should inquire into the methods of education. Many of our patients, I have no doubt, suffer severely from the strain of many hours' work, which, with or without glasses, is more than their eyes or brains can bear. Here is the daily programme of a "young ladies' finishing school," given me by a late pupil: Rise at 6 A. M.; work from 7 to 8:30; breakfast; work from 9:30 to 12 or 12:30 on alternate days; go out for a walk from 12 or 12:30 till 1; dinner; work from 2 to 5; tea; work from 6 to 8:30 or 9; go to bed at 9 or soon after; Sundays, a half holiday. With the exception, therefore, of Sunday, the daily routine was not less than nine hours of work, and not more than one of exercise. Such a system requires no comment from me, and will, I think, be condemned by all reasonable beings.

Mr. Critchet said that he ventured humbly to suggest that the general physician should seek the aid of the ophthalmic surgeon at an early period in cases of persistent headache. He called attention to the importance of seeking whether there were insufficiency in these cases. Prof. Liebrich had been our pioneer in this direction, and he has been well seconded by Dr. Landolt, of Paris. The former relied chiefly on the use of prisms, and the latter had recourse to operation.

Dr. C. H. May (*Medical Record*) gives the results of his experiments in transplanting rabbits' eyes. The medical world was most incredulous when the first case of transplantation was reported. Experience, however, has proved it possible for an eye to live after removal from its own orbit into another; but, with our present knowledge, it is of doubtful expediency—only in a very small percentage of cases is the result good enough to dispense with the necessity of an artificial eye. We still hope that improvement in

the method of operating may give us a substitute for glass eyes.

The first transplantation was made by Dr. Chibret, May 4th, 1885. The result of this operation was unsuccessful, the cornea having sloughed, and leaving a deformed stump. M. Terrier performed the second operation, which also resulted in destruction of the cornea on the third day. M. Rohmer did the third transplantation, which terminated as his predecessors' cases had done.

Dr. Bradford reported in the *Boston Medical and Surgical Journal*, of September 17th, 1885, the first successful case. The eye in his patient remained with good tension, cornea partially clear, conjunctiva congested, with ocular movements good up to the eighteenth day, when his report ends.

To further test the feasibility of the operation, Dr. May performed a series of twenty-four operations upon rabbits, with a very moderate degree of success. He united the optic nerves with catgut sutures, and muscles, conjunctiva and subconjunctival tissues with iron-dyed silk. Antiseptic precautions were thoroughly carried out, and the lids united with sutures which were covered with compresses of borated cotton and pressure bandage, and the whole covered by a mask. In the first seven cases, which were left unbandaged, degeneration of the cornea invariably took place. The next seven cases were bandaged, but the incessant attempts of the animal to remove the insecurely applied bandage left the eye in an unhealthy condition, so that the cornea degenerated soon after its removal. In four other cases, the dressings were removed too early, and the eye rapidly degenerated. The remaining six of the twenty-four cases were protected with the mask, and the result was satisfactory. The effect of air upon a cornea of low resisting power is thus shown to be very injurious. Dr. May thinks the injurious effects of the air are due to the foreign particles irritating the exposed cornea, or, what is more likely, to evaporation of moisture and lessened lymph supply.

"Under the microscope the cornea was found infiltrated with small, round and polygonal, and large fusiform cells, chiefly between the corneal fibers, and the latter were more opaque than normal; the epithelium of the surface was wanting in some places, and at others was markedly increased, causing a heaping up of cells."

In all cases, the sutured ends of the optic nerves became united by connective tissue, but no nerve elements passed from the nerve to the eye. The retina remained invariably degenerated.

An interesting address was given by Jonathan Hutchinson on Choroiditis Disseminata at the last meeting of the British Medical Association, in which he discussed the relation of the disease to syphilis.

Many interesting cases were related, and, as a result of his investigations, he arrived at the following propositions:

1. That concussion of the eyeball might produce conditions closely resembling those of other forms of choroiditis, but always limited to the eye injured.

2. That choroiditis disseminata, affecting both eyes, was occasionally met with as a family disease, independently of syphilis, and in association with disorders of the nervous system, especially of the intellect.

3. That there were cases of choroiditis which occurred in fairly healthy persons, which showed a remarkable tendency to recurrence, which were accompanied by iritis, and ought possibly to be grouped with relapsing iritis.

4. That young men were liable to a peculiar form of hæmorrhagic choroiditis, which was not dependent upon syphilis, but which produced results not to be distinguished from the syphilitic form.

5. That there were other forms of disseminated choroiditis which could not be assigned to any of the above groups, but which closely resembled, in their results, what we observed in syphilis, but in which there was still no reason to suspect that disease.

Mr. Hutchinson also said that, whilst it was to be freely admitted that in nine cases out of ten, the discovery of the results of choroiditis disseminata amounted to the discovery of antecedent syphilis, the symptom was yet one which must be received with caution, and could be trusted only when it was supported by other facts.

Mr. Critchett said that he would have been more inclined to attribute nineteen cases in twenty than nine in ten to acquired or inherited syphilis. He deemed it most important that anti-syphilitic treatment should extend over some years.

In an address on "The Future of Pathology," delivered before the Pathological Society of London (*Brit. Med. Jour.*, Jan. 22, 1887), Sir James Paget makes the following thoughtful observations:

We are sure that there are certain conditions which are justly called predispositions to disease; but in what many of these consist we are quite ignorant. There are diseases or disorders which we must be content to call functional, though I suppose none of us would hold that there can be any change in the working of a part without a change in its structure or composition. We know that certain disorders, such as typhoid and scarlet fever, are apt to be followed by certain other disorders which we call their sequels; but we have not yet shown the changes, of which the sequence is a necessary consequence. We know that different morbid conditions may be combined, as in diseases which we call hybrid or mongrel; we can recognize many of these combinations during life; they are things to be "attended to," as we say in treating cases; but of the allied varieties of morbid changes of structure or composition, and of the lessons they would teach, we know, I think, at present very little. * * *

The protoplasm in every structure, or of every embryo, must be as essentially different from that of every other as is the structure or the creature which in due time it may become.

THERAPEUTICS, DERMATOLOGY AND VENEREAL DISEASES.

By G. CROCKER SIMMONS, M. D.

The use of gelatine in bougie form as a carrier of local medicines, and, at the same time, as a dilator of the urethral canal, has seemed theoretically correct. Practically, so far, their application has been limited, and justly so. Several instances can be recalled where the undissolved bougie, so confidently recommended as entirely soluble, has been with great straining forced from the canal the next day. The patients, in the meantime, suffering excruciatingly from retention.

It certainly appears as if the combination of metallic salts, with gelatine as a base, interferes with the solubility, and, until that property is perfectly assured, great caution should be observed in their use.

The *Revue des Hopitaux*, in a late issue, mentions a new treatment of gonorrhœa. It consists in the injection of a one per cent. solution of natri. bicarb. repeated frequently. The object is to render the discharge neutral or alkaline. Test papers are used, and, as they show the secretion to be neutral, the injections are repeated at longer intervals. Up to the time of the report, but twelve cases, in which this plan had been followed, had been under observation. These had all done well.

Dr. Stuver, of Wyoming Territory, mentions in the *Therapeutic Gazette*, December 15, 1886, the benefit derived from the use of stigmata maidis in the acute stage of gonorrhœa. He asserts its positive value in allaying the pain and irritation of the first stage. A drachm of the fluid extract in water, combined with ten grains potass. acetat, every two hours, is his method of giving the drug.

In the second edition of Zeissl's "Outlines on the Pathology and Treatment of Syphilis and Allied Venereal Diseases," the author, while believing mercury of value in causing disappearance of symptoms, deprecates its use in the

early stages as pernicious, by rendering the patient more liable to relapses and to the more serious dangers of cerebral and visceral complications. The healing of the initial lesion, in his opinion, is best advanced by cleanliness, the application of iodoform, and the emplastrum hydrarg.—mild caustics being used in exceptional cases. Abortive treatment by excision or caustics is considered by him of no value.

His main reliance appears to be on iodine, which he declares, "in proper quantities, and in conjunction with a carefully regulated regimen, is sufficient to cause the symptoms of syphilis to disappear, or at least to be weakened, so that only a few mercurial inunctions will be necessary to complete the cure, without fear of relapse occurring in years to come."

The author's extended experience entitle his views to a large share of consideration, though they are somewhat at variance to those of the majority of the profession.

Dr. Edw. Welanders, in the *Nordiskt Mediciniskt Archiv*. (vol. xviii), gives a series of experiments on the absorption and elimination of mercury in the human organism. The results may be summarized as follows:

The exhibition of the drug *per anum* caused its appearance the following day in the urine; through the mouth, not for a day, or even two days; through the skin, it appeared on the following day. It is rapidly absorbed by wounds, ulcers, and when injected under the skin.

The urine is the great excretor—the feces also contain mercury, and frequently in considerable quantities. The salivary glands excrete but small quantities.

Welanders limits the impregnation of the system with mercury, after a course of treatment, to months rather than years, and disbelieves the statement of Paschkis and Vajda that it may remain for twelve years in the body after all treatment has been discontinued.

SOCIETY PROCEEDINGS.

Sacramento Society for Medical Improvement

Regular Meeting, Tuesday, Jan. 18, 1887.

The President, W. H. BALDWIN, M. D., in the Chair.

Sanitation in Sacramento, by H. S. NICHOLS, M. D.—The doctor, while fully realizing the importance of the subject, and sanitation in general, as receiving the attention of medical men all over the world, contented himself with giving the topography of the city, the circumstances which caused its location on its present site, rather than one apparently more eligible a few miles below. A history of its early and present system and condition of sewerage was given, with the source of water supply in abundance, which could be used for flushing.

The city was traversed from north to south by five main sewers, into which emptied twelve cross sewers, running east and west. The whole system united at Sixth and M into one main channel, terminating at Sixth and Y streets, at which point there were pumping works to convey the collected sewerage over the levee into the river, when there was not sufficient flow to take it to the drainage canal.

In addition to the foregoing there were many of the old plank sewers; these were of little use, but, on the contrary, a source of evil. Attempts had been made, from time to time, by the Board of Health and City Trustees to have them replaced by modern sewer pipes, but property holders, who seemed to feel that a trifling expense was more to be dreaded than the danger of epidemic disease, had so far prevented the change. The arrangement for the disposal of sewerage matter at Sixth and Y streets was not satisfactory. Pumping the city's filth into the river was a measure of doubtful propriety, as it inflicted upon those residing further down the stream the same evils that we complained of from those above us. In many cities in the East and in Europe, systems of sewerage were employed which enabled the refuse to be used for fertilizing purposes. The same method could be adopted in Sacramento with manifest benefit.

In spite of many natural disadvantages, the following statistics showed that Sacramento compared most favorably with other cities in the United States and elsewhere:

	Death rate per 1000 in 1885.	Population.
Boston	19.00	280,000
Charleston	28.88	60,000
Kansas City	11.40	105,000
New Orleans	28.52	234,000
New York	25.53	1,397,395
Oakland	12.79	43,000
St. Louis	18.72	400,000
St. Paul	12.00	111,000
San Francisco	19.00	280,000*
Washington	24.07	200,000
Dublin	27.6	353,080
Edinburgh	18.4	146,700
London	19.05	4,083,928
Paris	23.06	2,240,000
Vienna	27.09	769,890
Sacramento	13.54	30,000
Sacramento	15.19	30,000*

(Returns from 32 cities have been omitted.)

This table showed that Sacramento had, with three exceptions the lowest death rate of any important city in the United States, while it compared most favorably with the large cities of Europe. With this result, in the face of many natural disadvantages, it was evident that a minimum death rate could be attained when the resources of modern sanitary engineering were rendered available.

The discussion on the paper was postponed.

Sacramento Society for Medical Improvement

Regular Meeting, Tuesday, Feb. 15, 1887.

The President, W. H. BALDWIN, M. D., in the Chair.

The discussion on Dr. Nichols' paper on "Sanitation in Sacramento," which had been postponed at the last meeting, was taken up.

In opening the discussion, DR. SIMMONS said that the paper had interested him as a physician and as a citizen. He believed that the present method of emptying the sewerage into the river was indefensible as regards the residents further

* Death rate for 1886.

down the stream. It was also a waste of valuable fertilizing material, for use with which our soil was peculiarly adapted. Experiments elsewhere had proved that it was gold, not filth, which here runs to waste. The absence of mains in the eastern portion of the city, which had been mentioned by the author, was a matter which required immediate attention.

DR. BRIGGS fully concurred with the last speaker in regard to the pollution of the river, and the waste of sewerage. We who used the river water should be interested in its purity. We certainly ought to set a better example.

DR. TYRRELL remarked that the papers in San Francisco attributed the present epidemic of diphtheria to choked sewers. In this city the majority of cases had occurred in the eastern portion, where there were no sewers. Sewer gas was not the *cause* of diphtheria, though it was an important factor in its production. We had no right to pollute the river by emptying sewerage therein, and a law was needed to prevent this reprehensible practice.

DR. WHITE said that the "Shone System," which was in operation at the County Hospital, worked well; but he had not had sufficient experience with it to give an opinion on its merits.

DR. LAINE would not defend the system of sewerage disposal in operation at present; but, at the same time, he believed it was necessary, as a matter of expediency for self-protection. The method advocated by sewerage farms was impracticable on account of the expense attached to it. He doubted if we really inflicted great injury on those who lived further down the stream. We drank the water which had been polluted by a quarter of a million of people. If this water had not been purified in transit, we were drinking very filthy matter; whereas good authorities had declared that it was excellent water.

DR. OATMAN thought that this question had both a present and a prospective importance. The first step should be the provision of a complete system of sewerage, and next the disposal of the refuse matter. The doctor cited several cases where the absence of sewerage had been the cause of zymotic disease.

DR. VOELLER, on the causes of diphtheria, remarked that Professor Siegmund, of Vienna, during a cholera epidemic in that city, had called attention to the fact that none of the men working in the sewers had been affected.

DR. PATTERSON, of Cedarville, said that the people of Sacramento ought to be consistent. They would inhibit an industry which involved millions of dollars each year, because it injured the river; whilst here they were engaged in the same nefarious practices.

DR. NICHOLS, in replying, said that while he objected to dumping the sewerage in the river, he admitted that at certain seasons it was a necessity. He thought that a better method might be provided.

DR. SIMMONS wished to add that an expenditure in the amount which had been mentioned was not needed. The pumping apparatus was already in position, and only the necessary piping was required. Several years ago an offer had been made to take and dispose of all the city sewerage, if delivered without expense.

The Treatment of the Perinæum in the Parturient State, by J. H. PARKINSON, L. R. C. S.—The paper had been written rather to furnish matter for discussion, than to add a recapitulation to the already extensive literature on the subject. The question was one of great interest to the general practitioner, and the proper management of the perinæum during labor, with the treatment of injuries to this structure, was most important.

The causes of laceration may be divided into (a) Maternal; (b) Foetal; (c) External.

In the passage of the child, laceration was more frequently caused by the shoulder or elbow than by the head. This was explained by the existence of a tear in the vaginal mucous membrane, whilst the external structures remained intact. Apart from the unskilful use of instruments, there could be no doubt that the forceps favored the integrity of the perinæum in most cases, by moulding the head, maintaining its position, and advancing it between pains. The preventive measures were principally mechanical, and aimed at rectifying malposition, retarding precipitate descent, or expediting delivery. Support of the perinæum could not be advocated as a preventive measure. Leishman, a warm opponent of this practice having quoted from several authorities, said: "A careful study of these opinions amongst others, along with a thorough observation of the process in nature, led me long ago to condemn support of the perinæum as

irrational and useless in all cases and undoubtedly hurtful in some."

Prolongation of the sacral curve by the hand of the obstetrician, which carried the head upwards and forwards, was taught at the Rotunda Hospital, Dublin, as a substitute for support. Lusk advocates advancing the head between pains, by "alternately drawing the chin downwards through the rectum until the head distends the perinæum, and then allowing it to recede." Rectal expression, after the method of Ahlfeld and Olshausen, was a valuable resort. The results of lacerations which remained untreated depended on their degree. If extensive, impairing the functions of the anal sphincter, or destroying the integrity of the recto-vaginal septum, the consequences were disastrous. Slight tears which involved the posterior fourchette did not require interference. When the perineal body was involved operative procedure was imperative, as the antagonism of the transversus perenæi muscles, precluded union except by granulation. Lusk, very pointedly said: "Only a very credulous person really believes that he has witnessed union by first intention in extensive ruptures, as the result of tying the knees together and enjoining rest upon the side." With regard to the period of operation the weight of authority rested with immediate measures. The procedure was one which a practitioner of ordinary skill was competent to undertake. No special suture was required, the needle should pass deeply through the tissues; when the strain on the suture was considerable, silver wire was preferable; for superficial stitches and those approximating mucous membrane, catgut. Where there was extensive laceration of the vagina special instruments were required. It should be borne in mind that while affording the greatest possible assurance of success, immediate interference, if negative in its results, did not preclude the secondary operation.

Conclusions:

1. That direct support of the perinæum is injudicious and inadvisable, as tending to produce the injury which it seeks to avoid.
- 2 That pressure applied to the head directly, with a view of altering the axis, or retarding its descent, is proper under suitable conditions.
3. That interference with the perinæum by artificial dila-

tation, retraction, or similar manipulative procedure should be avoided, save under exceptional circumstances.

4. That every case where the perineal body has been involved, demands surgical attention.

5. That the proper time for operation is as soon as possible after the completion of the third stage.

DR. BRIGGS, in opening the discussion, said that in addition to the maternal causes of laceration noticed by the author, he would mention the fatty perinæum and œdema of the perineal tissues due to protracted or difficult labor. Both œdema and excessive deposits of fat diminish the elasticity of the perinæum, and increase its friability.

The chief instrumental causes are undue rapidity of delivery and improper axis of traction; by the former, delivery is effected before the perinæum has had time to dilate; and by the latter the insufficiently extended head is made to impinge too forcibly on the perinæum.

The position of the lying-in woman deserves consideration. The weight of the child and its direct impact should be removed as far as possible from the floor of the pelvis. Theoretically, a squatting position on the knees is best, but that on the left side fulfils the indications fairly well, and can be more readily adopted.

Next, we should seek to bring the smallest diameter of the presenting part into the lumen of the vulva. The efforts of nature in this direction are often frustrated by "support of the perinæum," and by too early attempts to crowd the head "well up against the symphysis." By these efforts the head is prematurely extended, and is made to emerge by its largest instead of by its smallest diameter. We should see that the occiput advances with the face until the suboccipital region is reached, when extension of the head and its delivery may be completed by crowding the head up, as recommended in the text-books.

Time is an important factor in the prevention of laceration. The patience and self-possession of the accoucheur are often taxed to their utmost. The obstetrician who drags the head through the undilated cervix is justly reprehended. Why is he less to be censured when he drags or forces the head, or even *permits it to pass* through the *undilated perinæum*? Oftentimes it will be necessary to retard the progress of the head and to force it back in the interval between the pains.

When rupture seems otherwise inevitable, lateral incisions may be practised.

The passage of the shoulders often causes laceration; unless imperative, haste should be avoided here, as in the delivery of the head. Rotation of the body should be promoted; the presenting shoulder being delivered first, and then the corresponding arm.

It is a serious error to draw the perinæum forward. In this way antero-posterior tension and thinning, instead of lateral tension and lateral thinning, are produced; the perineal tissues are wasted when they should be economized to their utmost; besides this, the expulsive forces are made to impinge more directly on the perinæum.

"Support of the perinæum" in obstetrics, like "protection" in political economy, is a very delusive term. Pressure on the thin and tense perinæum is objectionable—it promotes rupture instead of preventing it—and should be used only when the oncoming head can be delayed in no other way.

The methods of Olshausen and Fasbender, unless practised very discreetly, are likely to bring the chin forward, and deliver the head in one of its largest diameters. When combined with traction on the occiput, it may subserve a useful purpose.

In case of rupture, immediate repair under strict antiseptic precautions is ordinarily imperative. But if antisepsis is impracticable, operation should be deferred, as an open wound is far safer than a closed and infected pocket.

DR. HUNTINGTON said that the question of perineal laceration was one that did not directly concern him; he would, however, like to say a word in connection with operative procedure. Thomas had called attention to the fact that the first stitch was the important one; it should be buried throughout its entire extent. The "split shot" suture was an excellent one for this purpose.

The employment of antiseptics was a question which required consideration. In addition to its germicidal powers, the bichloride favored the formation, on the fresh wound surface, of that "sero-sublimate" which Lister had shown to be so important an aid to healing. For this reason it should receive the preference. Iodoform was useful, as it adhered closely to the parts. Frequent irrigation with mercurial solutions, was also desirable, as no permanent dressing was

possible. The speaker strongly favored the employment of the "gauze napkin" which was a safeguard, and very comfortable to the patient.

DR. OATMAN would discuss two points in connection with perineal laceration, namely: support, and securing the emergence of the smallest diameter.

It was formerly taught that support should be universal; but if this was followed, the pressure would be applied where the perinæum was attenuated to the utmost its integrity would endure, and it is a question whether pressure under such circumstances would strengthen or weaken its endurance. In all cases where laceration would naturally occur the foetal head was an imperfect cone, the face being the base and the apex presenting. To accommodate its smallest diameters to the vulvar outlet was, in his judgment, the most important preventive of laceration. This was often done involuntarily by pressure upon the distended perinæum. The method successfully practised by the doctor for several years, had been recommended and condemned by able obstetricians. In all cases of vertex presentation, where the vertex (cone) emerges from the *os uteri* and the perinæum is being distended, gentle pressure upon its posterior aspect, and, if necessary, through the rectum on the foetal forehead, with a decidedly forward tendency. As the head emerges from under the arch of the pubis it is easily made to pass in front of the symphysis, the arch, so to speak, drops upon the back of the foetal neck, which compels the vulvar outlet to retract over the head around its smallest possible diameters, from the vertex successively to the face. It was necessary to guard adjacent soft parts against undue pressure, but the foregoing method would not impair their integrity.

DR. NICHOLS believed that, *as a rule*, there should be no laceration of the perinæum. He considered this accident to be a very grave one. Patience and due observance of the relative position of parts and their conditions were essential for the obstetrician. He believed that support, when properly used, was desirable. During labor, preferred the position on the left side. Laceration by the shoulder could be avoided if pressure was made directly on the point of the acromion so as to carry it over the fourchette. He believed that if early operation was employed no permanent damage would ensue.

DR. LAINE believed in supporting the perinæum when the head rested on that structure; even if it did press the head forward, it undoubtedly increased the dilatation of the parts. In rapid labor the accident was most likely to occur, and he deprecated haste on the part of the accoucheur. Lateral incisions were good in theory, but he thought it would be rather difficult to carry them out in private practice. When rupture had taken place the immediate operation was desirable. Any antiseptic might be adopted, but in his opinion cleanliness was usually sufficient.

DR. VOELLER said that this subject had been a prominent feature in the lectures of Professor Ritgen, of Geissen. He remembered, in 1852, that Ritgen said: "If I had done nothing else to aid the progress of midwifery than these directions for the preservation of the perinæum, I would deserve eternal remembrance." Ritgen's method consisted in:

1. The position on the left side.
2. Retarding descent of the head by pressing with the points of the fingers on each side of the middle line, especially if a large head presented; this pressed the chin aside and allowed consecutive passage of the tubers.

4. Scarifications of the *ostium vaginae*, followed by irrigation with warm water to promote bleeding. He stated that an incision one line in depth gave three lines of expansion.

In delivering the shoulders Ritgen advocated keeping one shoulder on the perinæum, and releasing the arm of the upper shoulder from beneath the symphysis, allowing it to emerge first.

He believed in fomentations and inunction, particularly in primiparæ.

With regard to the results of laceration, authorities were not unanimous that they were so disastrous. Emmet said that simple laceration, even when extending to the sphincter, was not sufficient to cause displacement of the uterus; there must be some unknown factor involved. In cases of untreated rupture we found, after many years, that the parts still preserved their normal relations; whilst the result of a perfect operation for repair was often unsuccessful. Emmet believed that the descending head often tore the posterior vaginal wall from its attachments to that portion of the pelvic fascia which connects it with the rectum, long before it had begun to distend the perinæum.

DR. McKEE observed that the relative directions of the upper and lower portions of the parturient canal should be borne in mind. Practically, they formed a right angle. He thought that the application of the straight forceps in cases where the occiput did not engage, under the symphysis, or where complete flexion did not occur, was preferable to any manual expedient.

DR. PATTERSON, of Cedarville, in twenty years of practice, had never seen a case of laceration. Good common sense was the best aid. Slowness and patience were also necessary. In connection with instrumental delivery, the doctor alluded to an anecdote of Dr. Goodell's, contained in Prof. Gross' paper (*Journal Am. Med. Ass.*, Sept. 27, 1884). He believed that the forceps was too frequently applied for the convenience or comfort of the obstetrician. He thought that pressure, which prevented the emergence of the occiput, was a mistake. He was strongly in favor of antisepsis and strict cleanliness, and always used glycerine and carbolic acid for the hands during labor.

DR. BRICELAND, of Shasta, had heard the question discussed many years ago by Charles D. Meiggs, of Philadelphia. He was glad to see that the profession had not retrograded. He believed that the debate this evening represented the theories of modern scientific midwifery, but, at the same time, he must say that no advance had been made from the period he mentioned.

THE PRESIDENT observed that in young, muscular, well-knit women he often, on examination, experienced a difficulty in introducing the finger. In these cases he had found it advantageous to draw the perinæum downwards and backwards, so as to aid dilatation. Raising the hips from the bed was also a help, though he could not explain why, but it often facilitated delivery. He believed in making pressure on the occiput between pains.

Dr. Parish mentions (*Journal Am. Med. Ass.*, Feb. 5th, 1887) the fact that iron-dyed silk ligatures within the abdominal cavity had completely disappeared at the end of eighteen months. The case was one of cystic disease of the ovaries. Death subsequently took place from other causes, and the absence of the ligatures was demonstrated at the autopsy.

The Sacramento Medical Times.

JAMES H. PARKINSON, L. R. C. S. I., EDITOR.

SACRAMENTO: MARCH, 1887.

THE SACRAMENTO MEDICAL TIMES.

Starting upon its career as "another medical journal," THE TIMES is exposed to the inevitable criticism which greets a first number. In view of this, a brief statement of its position, present and prospective, is desirable.

THE TIMES neither seeks to supplant its contemporaries, nor comes to supply a demand, but rather to create one; and in proportion as the effort succeeds, its purpose will be accomplished. It will provide a means of communication in professional matters, a source through which to interchange practical medical experience, for the great body of the profession of the interior of the State. Circulating largely in Nevada, Oregon, and Washington Territory, it hopes to fulfil the same purposes in those fields where no local publication exists. Beyond this, that it is first Californian and Pacific Coast, the TIMES disclaims identity with any particular locality. Its columns are always open to correspondents, and as far as a monthly journal can accomplish, it will give prominence to this department, and special attention to matters of local interest.

Recognizing the fact that a scientific medical monthly does not exist outside the great Eastern cities, it hopes to attain its object as a medical journal by keeping these points in view. Yet, while admitting the primary impossibility of this desirable elevation, it will aim at the highest possible standard, and its pages will represent the best attainable

matter. When occasion demands, articles will be written by those whose special knowledge or wide experience renders them most competent to direct professional opinion on the subject. THE TIMES is published in the interests of the regular profession, and we desire at the outset to express our allegiance to the laws, written and unwritten, which govern that body. Its policy will ever be in sympathy with the National Association and all affiliated societies.

Believing that journals, like individuals, should practise what they preach, we desire to make our advertising department conform to our general policy. While direct endorsement is withheld, there can be no doubt that the appearance of any matter within the covers of a publication, conveys a tacit acquiescence. Conscious of the propriety of our course, we have determined that no patented or proprietary medicine, by which is meant a combination of known drugs, whose manufacture in that form is secured by statute to one person or firm, shall be advertised in our pages. This class of business properly belongs to the secular press, and we would endeavor to direct it into the course which it should take. It is a new departure, perhaps unique, but we are willing to make the experiment and abide by the results. We seek the support of the legitimate manufacturing pharmacist, and will properly notice advances which may be of benefit to the practitioner.

Published in its midst, we claim the support of the profession of the interior. As an independent journal, unconnected with any other enterprise and run solely in the interests of its subscribers, we appeal to all whom it may concern and we shall rely upon our intrinsic merit as the ultimate measure of our success.

AN ASYLUM FOR INSANE CRIMINALS.

When all other means of escape from a conviction of the gravest of crimes appear hopeless, our sharpest lawyers often set up a plea of insanity for their clients, and in many cases such a plea has been pressed upon the weakest foundation to a successful issue. Among the most effective agents to secure such a result, are medical men who are summoned into the service of the State to play an important part in the old farce of hypothetical questioning before judge, jury and crowded court-room. In these cases, what medical witness has not felt the humiliation of a position where he cannot explain his belief, and where he is compelled to answer yes or no to queries involving the most complicated problems in mental science?

A remedy for the evils connected with this plea has often been suggested in the medical literature of California, but no effort to change our system of judicature in this matter has been attempted until the present session of the Legislature. We are now happy to announce that Senator Boggs, of Colusa County, has introduced an Act which, if it become a law, will entirely remove the motive which now exists for a plea of unsound mind in cases where bloody crimes have been perpetrated. The new Act is founded upon the just and reasonable idea that, if the defendant has truly committed a murderous deed, even under an insane impulse, or when fully insane, the safety of society demands that he or she be provided with quarters in an asylum at San Quentin, where no further opportunity will be offered for the gratification of such dangerous tendencies.

The Act also provides that all insane criminals now under treatment at the asylums in Stockton or Napa, shall be re-

moved to the new institution. When it is known that these insane criminals are often necessarily associated with sufferers from mental disease sent from our most respectable families, no good citizen will protest against the passage of an Act which separates them for all coming time.

THE NEW MEDICAL REGISTER.

A third edition of the "Official Register of Physicians and Surgeons in the State of California," has just been published under the direction of the Board of Examiners of the State Society. This volume, which is larger than its predecessor, bears evidence of most careful attention to details; nothing has been omitted which would facilitate reference. The recapitulation of medical practitioners, by counties, which was formerly confined to licentiates of the Board, has, in this edition, been continued through the whole list, including "Illegals." Footings of the different counties have been appended, which show at a glance those in active practice and those who have retired.

The total number of certificates which have been issued by the Board is 2071, being an increase of 373 since the publication of the last Register. Of these, 1437 have been reported as residing in the State, 1335 of whom are in active practice.

The total number of persons practising medicine in California is 1879; of these 164 are classed as "Illegals." Estimating the population at 1,100,000 the proportion of practitioners to inhabitants is 1 to every 585 persons. It would appear that some agency has been successfully working to reduce the number of "illegal practitioners." In the second edition of the Register 485 names were included under that head. In the present volume the number is 164, being a

decrease of 321, during which period the whole number of resident licentiates has been increased by 164.

Want of space compels us to omit a more extended notice of other improvements and new features. The labor incident upon the publication of the Register has been necessarily great, and the thanks of the profession are justly due to the indefatigable Secretary of the Board, on whom most of this arduous work has fallen.

**THE STATE BOARD OF HEALTH AND THE PREVENTION
OF EPIDEMIC DISEASE.**

A clause was introduced in the General Appropriation Bill, providing the sum of one thousand dollars for use by the State Board of Health in preventing the introduction of contagious and infectious diseases. In committee, the amount has been wisely increased to twenty thousand dollars, and we trust that the amendment will meet with the approval of both branches of the Legislature.

Our State stands unrivaled in climate and general resources with any other State in the Union, and is now attracting a large share of the most desirable immigration from the older and less favored States; but should any of the exotic diseases, about which we hear so much, gain a foot-hold amongst us, either north or south, it is certain that all of this influx would be immediately checked, and our State thereby sustain such a set-back as a quarter of a century would but feebly repair.

It should be recollected that the money asked for is to be kept under the control of our Governor, and to be disbursed only by his consent. The State Board of Health is merely *advisory*; it will be its duty to notify the Governor of approaching danger, and of the means which should be adopted

to ward it off as speedily and effectually as possible. Never was the adage, "an ounce of prevention is better than a pound of cure," more unmistakably important to a people than to us at present. The diseases referred to are clearly preventable.

Our knowledge of the laws of health and hygiene demonstrates the fact that from twenty-five to thirty per cent. of the human family are now rescued from the subtle enemy in excess of that which was saved a quarter of a century ago, and greater results are still in store for us. Dr. Rush confidently looked forward to the day when Courts of law would punish cities and towns for permitting any of the sources of contagious or infectious diseases to exist within their jurisdiction; and Carlyle believed that neglect on the part of constituted authorities to adopt all possible means for the prevention of disease was a "punishable offense."

A few years ago our State was unquestionably saved from an epidemic of small-pox by the timely intervention of the State Board of Health. The Board, however, had no money at its disposal, but Governor Perkins, in his well-known generosity, came to the rescue, and pledged his private means for the purpose. Less than two years since, Governor Stoneman came to the assistance of the Board in like manner, and yellow fever was prevented from reaching us from Mexico.

The Southern Pacific Company also lent the Board its powerful aid in both instances. Such liberality, however, cannot always be relied upon, and should not be expected. The amount asked for should be cheerfully granted—with it much may be done, while without it the worst consequences may ensue. Should a penny wise and pound foolish spirit on the part of our legislators defeat the appropriation, and yellow fever, small-pox, cholera or other preventable disease, ever

reach us unnecessarily, it will then be too late for regrets; the seed will have been sown, and a harvest of death and desolation will be their and our reward. Let the clause be enacted without delay, and there can be no doubt whatever that the taxpayers throughout the State will cry Amen! with such unanimity as never has been accorded to any public measure.

IRA E. OATMAN, of Sacramento, has been appointed a member of council of the Section of Obstetrics of the Ninth International Congress.

WE would direct the attention of our readers to the subjects of insane criminals and the provision of funds for use by the State Board of Health, which have been noticed in the editorial columns. The opinions therein expressed have that authority which extended experience with the questions under discussion necessarily confers.

WE have been requested to mention that copies of the third edition of the "Official Register of Physicians and Surgeons" have been sent to the secretaries of the different local societies throughout the State for distribution in their immediate vicinity. Other physicians will receive the Register direct from the office of the Board of Examiners. Members of the profession in Sacramento can obtain their copies by calling at this office.

Licentiates of the Board of Examiners.

At special meetings of the Board of Examiners of the Medical Society of the State of California, held January 10th and 13th, 1887, the following physicians were granted certificates to practise medicine and surgery in this State:

Wm. E. Conlan, S. F.; M. Dep. Univ. Cal., Dec. 3, '86.
Geo. Corcoran, S. F.; Univ. of Glasgow, Scot., April 29, '49.
A. J. Dean, Haywards; M. Dep. Univ. Cal., Nov. 7, '81.
John R. Doig, San Diego; Coll. Phys. and Surgs., Chicago, Ill., March 11, '84.

Robert R. Dorsey, Los Angeles ; M. Dep. Univ. Penn.,
March 15, '82.

M. E. Gonzalez, S. F.; Cooper M. Coll., Cal., Nov. 6, '83.

A. B. Gregory, San Luis Obispo; Jefferson M. Coll., Penn.,
March 15, '82.

Thomas Keefe (duplicate), San Diego; Cooper M. Coll., Cal.,
Nov. 4, '82.

T. H. Kingsley, Lower Lake; M. Dep. Univ. Cal., Dec. 3, '86.

John Lagan, S. F.; King and Queen's Coll. Phys., Oct. 8, '86;
Royal Coll. Surg., Ireland, July 29, '86.

Ernst Lichau, S. F.; Univ. of Wurzburg, Ger., July 14, '86.

L. F. Mansfield, Santa Barbara; Woman's Hosp. M. Coll.,
Chicago, Feb. 29, '76.

J. M. Mathewson, Oakland; M. Dep. Univ. Cal., Nov. 10, '82.

W. T. Maupin, San Jose; Jeff. M. Coll., Penn., March 10, '64.

T. J. McDonald, S. Diego; Univ. Vic., Canada, May 12, '86.

B. A. Rabe, Oakland; M. Dep. W. Res. Univ. O., Feb. 7, '71.

W. M. Ryer, S. F.; M. Dep. Univ. City of N. Y., —, '45.

J. P. Sargent, S. F.; Bell. Hosp. M. Coll., N. Y., May 1, '86.

C. F. Taggart, Tulare; St. Louis M. Coll., Mo., March 5, '84.

F. W. Trull, S. F.; Bell. Hosp. M. Coll., N. Y., March 15, '86.

A. H. Warren, Los Angeles; M. Dep. Univ. City of N. Y.,
March 6, '86.

G. W. Zimmerman, Woodland; M. Coll. of Ohio, March 2, '68.

At the regular meeting, held February 2d, 1887, certificates were granted to the following:

F. B. Elwood, Alhambra; Kansas City M. Coll., Mo., March
7, '82.

S. E. Morse, San Lucas; M. Dep. Univ. Kansas City, Mo.,
March 2, '82.

E. D. Seaman, Wilmington; Coll. Phys. and Surgs. City of
N. Y., Oct. 2, '83.

W. N. Smart, San Diego; Long Island Coll. Hosp., N. Y.,
June 22, '71.

At a special meeting, December 8th, 1886, the application of R. E. Foley, of Janesville, was rejected because of insufficient credentials.

At a special meeting, held January 13th, 1887, the application of Wm. H. Sommers, of Moore's Station, was rejected because of insufficient credentials. He presented to the

Board a long affidavit, asserting that he graduated at the Chicago Medical College, but the records of that institution show that he did not graduate there. He subsequently wrote a letter to the Board admitting the falsity of his affidavit.

The application of Chalmer M. C. Prentiss, of San Francisco, who calls himself in his advertisements, "Dr. Prentice," was rejected at a special meeting of the Board, held January 26th, 1887, because of unprofessional conduct. Pending the investigation of his case before the Board, he sued out a writ of mandate in the Superior Court to compel the issuance of a certificate. The suit terminated in favor of the Board.

R. H. PLUMMER, Secretary.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT OF THE U. S. ARMY (DIVISION OF THE PACIFIC), FROM JAN. 19 TO FEB. 20, 1887.

Lieut. Edward R. Morris, Asst. Surgeon, granted leave of absence for one month, to take effect on or about March 10, 1887, with permission to apply for an extension of twenty days. (S. O. 6, Div. Pacific, January 19, 1887.)

Asst. Surg. M. M. Walker, relieved from duty at Angel Island, Cal., to report to the Commanding General Dept. Columbia for temporary duty in that Department. (S. O. 8, Div. Pacific, January 25, 1887.)

Lieut. Leonard Wood, Asst. Surgeon, to proceed to headquarters and report to Department Commander for temporary duty. (S. O. 12, Dept. Arizona, January 31, 1887.)

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL CORPS, U. S. NAVY (DIVISION OF THE PACIFIC), FROM JAN. 20 TO FEB. 20, 1887.

Norfleet, E. H., P. A. Surgeon, reported for duty at Naval Hospital, Mare Island, February 5th.

Green, E. H., P. A. Surgeon, assigned to duty on U. S. S. "Alert" under orders to Central American Coast, etc.

Dungan, J. S., Medical Director U. S. N., has been placed on the retired list January 29th.

Robinson, S., Medical Inspector U. S. N., has reported at San Francisco January 29th.

METEOROLOGY.

STATIONS.	TEMPERATURE.			HUMIDITY.		WEATHER.			WIND.	FURNISHED BY.
	Highest.	Lowest.	Mean.	No. days Rain fell	Total Rainfall.	No. of Days			Prevail- ing direction	
						Clear.	Fair.	Cl'dy.		
Los Angeles, Cal.....	73.8	36.3	51.9	10	9.32	17	5	9	W.	Lieut. Maxfield, U. S. S. C.
Red Bluff, Cal.....	56.7	30.6	43.9	14	4.95	6	12	13	N.	
Sacramento, Cal.....	60.0	30.0	48.7	12	5.91	12	7	12	N. W.	
San Francisco, Cal....	59.9	33.1	47.5	16	8.80	12	11	8	N. W.	
San Diego, Cal.....	68.7	39.0	53.0	11	4.43	16	9	6	N. W.	
Santa Barbara, Cal....	

For Month ending February 20th, 1887.

CLEAR DAY—One on which cloudiness is 3 or less on a scale of 10.

FAIR DAY—One on which cloudiness is from 3 to 7.

CLOUDY DAY—One on which cloudiness is over 7.